



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
239 Causeway Street, Suite 200, 2nd Floor
Boston, MA 02114

<http://www.mass.gov/dph/boards/ph>

PH (617) 973-0960 FAX (617) 973-0980 TTY (617) 973-0895

**APPLICATION FOR RELOCATION TO MANAGE AND OPERATE
A NUCLEAR PHARMACY
Instructions and Checklist
Application**

Instructions:

Use this application to be issued a permit to manage and operate a nuclear pharmacy. The Massachusetts registered nuclear pharmacist who is responsible for the management and operation of the nuclear pharmacy must complete this application for registration to manage and operate a nuclear pharmacy and submit it to the Board **before** the pharmacy can operate.

The forms and documents listed below must accompany each application.

Checklist:

- _____ A completed checklist and application form, fully and properly completed and signed by the nuclear pharmacist who is to manage and operate the pharmacy.
- _____ A statement of the scheduled hours during which the nuclear pharmacy is to remain open, including the time of opening and closing during regular business hours for each day of the week.
- _____ A check or money order payable to the Commonwealth of Massachusetts for **\$525.00**. NOTE: Cash or foreign currency is not accepted. **This fee is non-refundable and non-transferable.**
- _____ An application for a Massachusetts controlled substance registration. Include a check or money order payable to the Commonwealth of Massachusetts for \$225.00. Cash or foreign currency is not accepted.
- _____ An official blueprint or certified architectural plans drawn to scale clearly designating the nuclear pharmacy

- _____ A copy of the corporation's Articles of Organization, signed and sealed by the Secretary of State if the corporation is incorporated in the Commonwealth.
- _____ If the corporation is incorporated in another state, submit a copy of the corporation's Foreign Corporation Certificate, signed and sealed by the Secretary of State pursuant to M.G.L. c.181, § 4.
- _____ A statement of the name and address of each officer and director of the corporation and the position held.
- _____ The d/b/a name of the business.
- _____ If the corporation is not publicly owned, list the total amount and type of stock issued to each stockholder and the names and addresses of said stockholder(s).
- _____ Any additional information as determined by the Board.
- _____ Submission of completed checklist, applications and fees acknowledges that the applicant understands and agrees to all provisions herein.
- _____ Retain a copy of the completed checklist, applications and supporting documents for your records.

For complete information regarding registration of a nuclear pharmacy, please refer to 247 CMR 13.00. Board regulations may be found at www.mass.gov/dph/boards/ph. If additional information is needed, please contact the Board office at (800) 414-0168. **All fees are non-refundable and non-transferable.**



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**APPLICATION FOR RELOCATION TO OPERATE AND MANAGE
A NUCLEAR PHARMACY – FEE: \$525.00 (Non-refundable)**

Please include either a certified check, money order, or personal check for **\$525.00** made payable to the *Commonwealth of Massachusetts*.

1. Nuclear pharmacies must be licensed (Radioactive Materials License) by the Department of Public Health, Radiation Control Program (DPH / RCP) prior to registration by the Board of Registration in Pharmacy.

Documentation of DPH / RCP licensure is attached. Yes _____

DPH / RCP license number _____

2. Legal name of nuclear pharmacy _____

3. **PROPOSED** relocation address of the nuclear pharmacy for which registration is requested.

Street _____ Phone (____) _____

City or Town _____ State _____ Zip _____

4. **PREVIOUS** address of this nuclear pharmacy:

Street _____ Phone (____) _____

City or Town _____ State _____ Zip _____

5. Email address for this Nuclear Pharmacy: _____

6. Hours of operation of nuclear pharmacy.

Day	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

7.. If the nuclear pharmacy is owned by an individual, state:

Name of owner _____

Address _____

Social Security Number _____

8.. If the nuclear pharmacy is owned by a partnership, state:

Partnership name _____

Address _____

FID # _____

9. If the nuclear pharmacy is owned by a corporation, state:

a. Corporation name _____

Address _____

FID # _____

b. State in which company is incorporated _____

c. Names of Corporate Officers

Name	Position

10. Pharmacist charged with the management of the nuclear pharmacy must be a Massachusetts registered pharmacist, and have been qualified by the Board as a nuclear pharmacist.

a. Name of pharmacist manager _____

b. Mass. Pharmacist Registration Number _____

c. Date of qualification by the Board as a nuclear pharmacist _____

d. Social Security Number _____

11. Name of other Massachusetts registered pharmacists in employment. If registered as nuclear pharmacists, state regulation numbers.

Name	Pharmacist #	Nuclear Pharmacist #

12. (a) Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or license for the manufacture, distribution, or dispensing of any drugs, including controlled substances, radiopharmaceuticals and radioactive materials? Yes _____ No _____

If yes, provide a full explanation. (Attach additional sheets if necessary)

(b) Have any applications for licensure been denied by any federal or state agency including any state board of pharmacy and or foreign jurisdiction? Yes _____ No _____

If yes, provide a full explanation. (Attach additional sheets if necessary)

*If you answered “Yes” to Question “12a or 12b”, you must attach a certified copy of each action and or court setting forth circumstances of such action(s).

Pursuant to M.G.L. Chapter 62C section 49A, the company certifies that it has complied with all laws of the Commonwealth relating to state taxes.

We hereby certify that we have read and understand all applicable state and federal statues and regulations regarding the operation of nuclear pharmacies and the handling of radiopharmaceuticals and radioactive materials, including M.G.L. Chapter 94C and Chapter 112, and 247 CMR 13.00 through and including 13.05.

WARNING:

In accordance with Chapter 94 M.G.L. Sec 13, the Board of Registration in Pharmacy in the case of a retail drug business or wholesale druggist, may suspend or revoke a registration to manufacture, distribute, dispense or possess a controlled substance after a hearing pursuant to the provisions of Chapter 34A and upon finding that the registrant has furnished false or fraudulent information in any application filed under the provisions of Chapter 94C.

RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.

ALL FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE

Signature of Owner, Partner, or Corporate Officer _____
Date _____

Signature of Proposed Pharmacy Manager _____
Date _____

Sworn and subscribed before me this _____ day of _____

My commission expires _____

Name of Notary Public

NOTARY SEAL

To be completed by the Board: Check \$ _____ Date _____ Number _____